STATE OF WISCONSIN
DEPARTMENT OF WORKFORCE DEVELOPMENT
Division of Workforce Solutions

Authorization to Administer Medication

Use of form: Completion of this form meets the requirements of DWD 55.08(4)(f), Wisconsin Administrative Code.

Instructions: Complete this form before any medication is administered. Place form in child's file when medication is no longer required/authorized.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m)].

Provider Name

Child Name	Date of Birth (mm, dd, yyyy)

MEDICATION

Medication Name	Dosage	Time of Day Administered	Medication Time Period (Dates) To	From
		☐ AM ☐ PM		
		☐ AM ☐ PM		
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Administering Medication - Special Instructions

AUTHORIZATION

I hereby authorize administration of the above medication(s) to my child by the childcare provider listed above.

SIGNATURE - Parent or Guardian	Date Signed